Medicare Learning Network
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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The Centers for Medicare & Medicaid Services (CMS) has completed the bid evaluation process and announced the single payment amounts for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Competitive bidding will determine where Medicare beneficiaries residing in Competitive Bidding Areas must obtain many DMEPOS items as of January 1, 2011. For additional information about the Medicare DMEPOS Competitive Bidding Program, visit http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ on the CMS website.

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Related CR Transmittal #: R2118CP
Implementation Date: January 3, 2011

Calendar Year (CY) 2011 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed

This article, based on Change Request (CR) 7248, advises you of the CY 2011 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. The annual update process for the DMEPOS fee schedule is documented in the Medicare Claims Processing Manual, Chapter 23, Section 60 at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2011. Be sure your billing staffs are aware of these changes.

Background and Key Points of CR7248

The DMEPOS fee schedule file is available for State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.hhs.gov/DMEPOSFeeSched/ on the CMS website.

2011 Update to Labor Payment Rates

2011 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 1.1 percent effective for dates of service on or after January 1, 2011 through December 31, 2011, and those rates are as follows:

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
AK	25.55	29.11	34.25		NC	13.56	20.21	27.44
AL	13.56	20.21	27.44		ND	16.90	29.05	34.25
AR	13.56	20.21	27.44		NE	13.56	20.19	38.26
AZ	16.77	20.19	33.76		NH	14.56	20.19	27.44
CA	20.81	33.19	38.68		NJ	18.30	20.19	27.44
CO	13.56	20.21	27.44		NM	13.56	20.21	27.44
CT	22.65	20.67	27.44		NV	21.61	20.19	37.40
DC	13.56	20.19	27.44		NY	24.98	20.21	27.44
DE	24.98	20.19	27.44		OH	13.56	20.19	27.44
FL	13.56	20.21	27.44		OK	13.56	20.21	27.44
GA	13.56	20.21	27.44		OR	13.56	20.19	39.46
HI	16.77	29.11	34.25		PA	14.56	20.79	27.44
IA	13.56	20.19	32.85		PR	13.56	20.21	27.44
ID	13.56	20.19	27.44		RI	16.17	20.81	27.44
IL	13.56	20.19	27.44		SC	13.56	20.21	27.44
IN	13.56	20.19	27.44		SD	15.15	20.19	36.68
KS	13.56	20.19	34.25		TN	13.56	20.21	27.44
KY	13.56	25.88	35.09		TX	13.56	20.21	27.44
LA	13.56	20.21	27.44		UT	13.60	20.19	42.73
MA	22.65	20.19	27.44		VA	13.56	20.19	27.44

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
MD	13.56	20.19	27.44		VI	13.56	20.21	27.44
ME	22.65	20.19	27.44		VT	14.56	20.19	27.44
MI	13.56	20.19	27.44		WA	21.61	29.62	35.18
MN	13.56	20.19	27.44		WI	13.56	20.19	27.44
MO	13.56	20.19	27.44		WV	13.56	20.19	27.44
MS	13.56	20.21	27.44		WY	18.91	26.94	38.26
MT	13.56	20.19	34.25					

HCPCS Code Updates

The following new codes are effective as of January 1, 2011:

- A4566, A9273, and EO446 all of which have no assigned payment category;
- A7020,E2622, E2623, E2624, and E2625 in the inexpensive/routinely purchased (DME) payment category:
- E1831 in the capped rental payment category (DME);
- L3674, L4631, L5961, L8693, Q0478, and Q0479, in the prosthetics/orthotics payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2011 DMEPOS Fee Schedule Update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes, where applicable, from January 1, 2011 through June 30, 2011. The new codes are not to be used for billing purposes until they are effective on January 1, 2011.

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

- E0220, E0230, and E0238
- K0734, K0735, K0736, and K0737
- L3660, L3670, L3672, L3673, and L3675.

For gap-filling purposes, the 2010 deflation factors by payment category are listed as follows:

Factor	Category
0.502	Oxygen

Factor	Category
0.506	Capped Rental
0.507	Prosthetics and Orthotics
0.643	Surgical Dressings
0.700	Parenteral and Enteral Nutrition

Specific Coding and Pricing Issues

Therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 Fee Schedule Update as described in Change Request 3574 (Transmittal 369) which may be reviewed at http://www.cms.gov/transmittals/Downloads/R369CP.pdf on the CMS website. The payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004.

As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code as follows:

- Fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the Calendar Year 2009;
- The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

Power-Driven Wheelchairs

In accordance with section 3136(a)(1) of The Affordable Care Act of 2010, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13. Payment amounts will be based on the lower of the supplier's actual charge and the fee schedule amount. As part of this update, the CY 2011 rental fees for power-driven wheelchairs included in the 2011 DMEPOS Fee Schedule Part B file have been revised to represent 15 percent of the purchase price amount. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR7248, which is at http://www.cms.gov/Transmittals/downloads/R2118CP.pdf on the CMS website. This attachment identifies those codes where payment, when applicable, will be made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through 13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.

Also, section 3136(c)(2) of The Affordable Care Act specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS Competitive Bidding Program. MLN Matters® article MM7181 at http://www.cms.gov/MLNMattersArticles/downloads/MM7181.pdf discusses these changes.

For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10% of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the MS modifier, for billing maintenance and servicing, as appropriate:

- K0010 Standard- Weight Frame Motorized/Power Wheelchair
- K0011 Standard- Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment, Tremor Dampening, Acceleration Control and Braking
- K0012 Lightweight Portable Motorized/Power Wheelchair
- K0014 Other Motorized/Power Wheelchair Base

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10 percent of the wheelchair's purchase price.

CY 2011 Fee Schedule Update Factor

The DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, section 3401 of The Affordable Care Act requires that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year". For CY 2011, the MFP adjustment is 1.2 percent and the CPI-U update factor is 1.1 percent. Thus, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent MFP resulting in a -0.1 percent MFP-adjusted update factor or a 0.1 percent reduction to the applicable CY 2011 DMEPOS fee schedule amounts.

2011 National Monthly Payment Amounts for Stationary Oxygen Equipment

CMS will also implement the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. The fee schedule file is being revised to include the new national 2011 monthly payment rate of $173.31 for stationary oxygen equipment. The payment rates are being adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new Oxygen Generating Portable Equipment (OGPE) class. The revised 2011 monthly payment rate of $173.31 includes the -0.1 percent MFP-adjusted update factor. The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from $173.17 to $173.31.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2011 Maintenance and Service Payment Amount for Certain Oxygen Equipment

Payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

The 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of $66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in section 1834(a)(14) of the Social Security Act. The 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted covered item update factor to yield a CY 2011 maintenance and servicing fee of $65.93 for oxygen concentrators and transfilling equipment.

Specific Billing Issues

Effective January 1, 2011, the payment category for code E0575 (Nebulizer, Ultrasonic, Large Volume) is being revised to move the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011 will be counted as the first rental month in the cap rental period.

Code A7020 (Interface for Cough Stimulating Device, Includes All Components, Replacement Only) is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental Durable Medical Equipment

cough stimulating device coded at E0482. Section 110.3, Chapter 15 of the Medicare Benefit Policy Manual at at http://www.cms.gov/Manuals/downloads/bp102c15.pdf provides that reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary Durable Medical Equipment only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment will not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for Ventricular Assist Devices (VADs):

- Q0478 (Power Adaptor for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type); and
- Q0479 (Power Module for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505, CMS has determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. CMS is establishing edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 (Power Pack Base for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only) should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

Additional Information

The official instruction, CR7248, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2118CP.pdf on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.